

## City of St. Louis MRC Application

Please fill out this form to join the City of St. Louis Medical Reserve Corps. Your information will be entered into the program database and will not be shared without your consent.



### Primary Contact Information

Last Name:		First Name:		Middle Initial:
DOB:		Gender: <input type="checkbox"/> M <input type="checkbox"/> F		Veteran: <input type="checkbox"/> Yes <input type="checkbox"/> No
Address:		City:	State:	Zip:
Home Phone:	Cell Phone:	Work Phone:		Ext.:
Pager:		E-mail:		

### Emergency Contact Information

<b>Primary Contact:</b>		Relation:	
Address:	City:	State:	Zip:
Phone:	Cell Phone:	Pager:	
<b>Alternate Contact:</b>		Relation:	
Address:	City:	State:	Zip:
Phone:	Cell Phone:	Pager:	

### Profession / Education

Are you a current student? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, what school do you attend?	
Employer:		Job Title:	
Employer Address:	City:	State:	Zip Code:
Work Status: <input type="checkbox"/> FT Student <input type="checkbox"/> FT Employee <input type="checkbox"/> PT Employee <input type="checkbox"/> Retired <input type="checkbox"/> Not Practicing			
Are you part of an emergency response plan with another organization? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, which one(s):	

### Professional License (If Applicable)

License Type:	State:	Lic. #:	Expires:
License Type:	State:	Lic. #:	Expires:

### Current or Most Recent Practice Setting

<input type="checkbox"/> Clinic Office / Administrative Student <input type="checkbox"/> Community Center <input type="checkbox"/> Government / Business <input type="checkbox"/> Health Department <input type="checkbox"/> Hospital <input type="checkbox"/> Maternal/Child Health	<input type="checkbox"/> Nursing Home / LTC Facility Other: <input type="checkbox"/> Public/Community Health <input type="checkbox"/> Private Practice <input type="checkbox"/> Research <input type="checkbox"/> Teaching / Academia <input type="checkbox"/> Sales/Marketing <input type="checkbox"/> Other:
---	--

# City of St. Louis MRC Application

## Volunteer Interests

- ☐ I would like to volunteer for **Ongoing Public Health Programs** only.
- ☐ I would like to volunteer for **Public Health Emergency** preparedness efforts only.
- ☐ I would like to volunteer for **Public Health Programs** and **Public Health Emergency Preparedness** efforts.

### Specific Interests (Select all that apply.)

- |   |  |
|---|--|
| <input type="checkbox"/> Disaster / Emergency Response    | <input type="checkbox"/> Mass Prophylaxis/Immunization |
| <input type="checkbox"/> Clinical Services                | <input type="checkbox"/> Special Needs Shelters        |
| <input type="checkbox"/> Community Health Education       | <input type="checkbox"/> Well-Child Immunizations      |
| <input type="checkbox"/> Communicable Disease Mgmt.       | <input type="checkbox"/> Program Building/Task Forces  |
| <input type="checkbox"/> Emergency Preparedness Education | <input type="checkbox"/> Other                         |

## Availability

Weekday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
<b>Duration</b>	<input type="checkbox"/> 1-2 Hrs <input type="checkbox"/> 3-4 Hrs <input type="checkbox"/> 4-8 Hrs <input type="checkbox"/> 8+ Hrs	<input type="checkbox"/> 1-2 Hrs <input type="checkbox"/> 3-4 Hrs <input type="checkbox"/> 4-8 Hrs <input type="checkbox"/> 8+ Hrs	<input type="checkbox"/> 1-2 Hrs <input type="checkbox"/> 3-4 Hrs <input type="checkbox"/> 4-8 Hrs <input type="checkbox"/> 8+ Hrs	<input type="checkbox"/> 1-2 Hrs <input type="checkbox"/> 3-4 Hrs <input type="checkbox"/> 4-8 Hrs <input type="checkbox"/> 8+ Hrs	<input type="checkbox"/> 1-2 Hrs <input type="checkbox"/> 3-4 Hrs <input type="checkbox"/> 4-8 Hrs <input type="checkbox"/> 8+ Hrs	<input type="checkbox"/> 1-2 Hrs <input type="checkbox"/> 3-4 Hrs <input type="checkbox"/> 4-8 Hrs <input type="checkbox"/> 8+ Hrs	<input type="checkbox"/> 1-2 Hrs <input type="checkbox"/> 3-4 Hrs <input type="checkbox"/> 4-8 Hrs <input type="checkbox"/> 8+ Hrs
<b>Time of Day</b>	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Flexible	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Flexible	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Flexible	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Flexible	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Flexible	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Flexible	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Flexible

## Other Information

Other volunteer commitments:	Approx. hours dedicated to other volunteer activities:
Special skills (languages, computer, etc.):	List any special needs or work restrictions:
How did you hear about the City of St. Louis Medical Reserve Corps?	Other information we should know about you:

I hereby certify that all information on this application is accurate and correct and hereby make application to the City of St. Louis Medical Reserve Corps. I understand that I am applying for a volunteer position and this is not an application for, nor a contract of, employment. I understand that this application does not automatically make me a credentialed volunteer and that further interviews and training will take place.

I understand that every attempt will be made to reduce the risks to volunteers; however some risks may be presented during a public health emergency or disaster.

I further understand and give written permission for the City of St. Louis Medical Reserve Corps to submit my name for criminal and driving background checks. Also, I realize that my professional licensure status will be verified.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Thank you for Registering!**  
**Return form to:**  
 City of St. Louis Department of Health  
 Attn: MRC Coordinator  
 1520 Market Street  
 Suite 4045  
 St. Louis MO 63103  
 Phone: 314-657-1546  
 E-mail: curtisp@stlouis-mo.gov